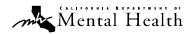


# LTCS BEST PRACTICE CATALOG SUBMISSION COVER SHEET

TYPE OF SUBMISSION:
NEW
X REVISED - Replaces <u>I. C. 1 015</u> Current submission catalog number
UPDATE - To  Current submission catalog number
CHANGE IN CONTACT INFORMATION
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Date Submitted To Hospital/Division:
Approved for submission to LTCS Best Practice Committee
Date Submitted To LTCS Best Practice Committee:
Approved for submission to LTCS Best Practice Catalog



### LTCS BEST PRACTICE CATALOG SUBMISSION

Proj	ect Title: Restraint	Flow Chart – (R / S	<b>Documentation Sheet</b> )	REVISED	
Func	etion Category:  X PATIENT-FO	OCUSED	ORGANIZATION	STRUCTURES	
Sub-	category(s): Care o	of Patient	Heading: Behavior M	<b>Aanagement</b>	
	act Person: Peggy l ail Address: <u>Pphakl</u>	Phaklides, RN ides@dmhash.state.ca.us	Telephone Number:	805-468-3396	
Hosp	oital: Atascade	ero State Hospital			
	following items are sample Flow Sheet	available regarding t	this Best Practice:		
	Photographs	Video Tape	— Drawings	—— Manual	
	ELECTION OF PR roject/process area for		AREA (Describe how and	why your team selected this	
a D	The State and Federal laws and regulations, as well as the JCAHO standards, governing the application and use of any form of restraint or seclusion have inherently stringent guidelines. Documentation surrounding the use of restraint or seclusion must then contain all the required elements to justify its use and ensure that the patient's rights have not been violated				
	new revised version Ilness	of this form includes	s 2 changes that furthe	er improve the form's	
R	A title change on the form including check boxes so the form can <u>either</u> be used or Restraint and Seclusion <u>OR</u> be used to chart 15 minute observations on patients who need very similar documentation but are not in restraint or seclusion.				

## 2. Documentation elements required from the new JCAHO Pain Management assessment standards.

## 2. <u>UNDERSTANDING EXISTING CONDITION WHICH NEEDS IMPROVEMENT</u> (Describe the relationship of your project to your goals for improvement, and describe current process performance.):

The Level of Care staff when documenting the patient's physical and mental condition, level of restraint used, nursing care given, fluid intake/output, documentation of the patient's behaviors every fifteen minutes, and summary documentation every two hours required the use of several forms located in different sections of the medical record. Due to the logistics of forms/documents within the chart, omission or incomplete documentation is possible. The absence of any of this vital information places the staff and hospital in a vulnerable position.

#### 3. **ANALYSIS** (Describe how the problem was analyzed.):

Ongoing chart audits by numerous departments, as well as the Patients' Rights Advocate revealed less than perfect documentation surrounding the use of restraint or seclusion. A consolidated method to document the nursing care provided and the patient's progress was deemed necessary to obtain a complete, current and ongoing picture of the patient's status.

#### 4. <u>IMPLEMENTATION</u> (Describe your implementation of the solution.):

A team of staff met to review all required elements R & S documentation, establish weak points and redundancies of chartings, and develop at tool, the "Restraint Flow Sheet", to solve the problem. The form is printed on 1-side, on an easily recognizable colored card stock page and is filed chronologically in the ID notes of the patient's chart.

## 5. <u>RESULTS</u> (Demonstrate that an improvement has occurred as a result of the project/process area implementation.):

The tool provides a 24hour tracking sheet which prompts the nursing staff to review and address the essential elements required in the documentation of a patient's status while in restraint or seclusion. Vital elements include 1) nursing care provided, e.g., ROM, I & O, vital signs, skin condition assessments, environmental conditions, etc.; 2) review of alerts for risk factors in the use of restraint or seclusion; 3) triggers for referral for consults if the patient is in R&/or S for greater than 72-144-216 hours; 4) denial of rights considerations; and 5) every 15 minutes observations of the patient's behaviors, and now, Pain Management Assessment. With the consolidation of numerous forms into one tool, in one location, the level of care staff are able to focus the written documentation in the

interdisciplinary notes to delineate the patient factors, (mental and behavioral) which justify the continued use of R&S.

### 6. <u>LEARNING</u> (Describe what the team learned and how they used those lessons to continuously improve the success of this Best Practice.):

The team found that incorporation of numerous requirements from several different sources, into an existing and already complicated system is fraught with numerous problems. Input solicited from all levels of the organization can help with buy-in and facilitate the process to a desirable outcome. The team also discovered that once the change and acceptance to the new documentation system was completed, the level of care staff found more time was available for direct patient care, less time was spent on the documentation, and compliance with the regulatory requirements was improved.